STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		005093	B. WING		07/30/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
WITHAM I	HEALTH SERVICES		EBANON ST N, IN 46052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 000	INITIAL COMMENTS		S 000			
	Complaint: #IN00137	oital complaint investigation. 7568 deficiencies related to the				
	allegations are cited.					
	Facility Number: 0056 Survey Date: 07/30/2					
	Surveyor: Saundra N Public Health Nurse S	olfi, RN				
	QA: claughlin 08/13/1	14				
S 912	410 IAC 15-1.5-6 NUI	RSING SERVICE	S 912			
	410 IAC 15-15-6 (a)(2 (iii)(iv)(v					
	(a) The hospital shall organized nursing ser provides twenty-four (service furnished or sregistered nurse. The have the following:	vice that 24) hour nursing upervised by a				
	(2) A nurse executive (B) responsible for the (i) The operation of th including, but not limit determining the types nursing personnel and to provide care for all areas of the hospital. (ii) Maintaining a curre service organization of (iii) Maintaining currer	e following: e services, eed to, and numbers of d staff necessary patient care ent nursing chart.				

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:			
		005093	B. WING		07	/30/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
WITHAM	HEALTH SERVICES		EBANON ST				
			N, IN 46052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	descriptions with reporesponsibilities for all positions. (iv) Ensuring that all repersonnel meet annurequirements as estated hospital and medical procedure, and federarequirements. (v) Establishing the sinursing care and pracesettings in which nurse provided in the hospital positions.	nursing staff nursing al in-service blished by staff policy and al and state tandards of ctice in all sing care is tal.					
	record review, and infailed to ensure the neperformed according whose medical record. The facility policy reviewed 05/2014, incomperature, respirated Apical pulse for 1 min murmur, Clear breath grunting, flaring, or retemperature: 97- 99 Femperature: 97- 97- 97- 97- 97- 97- 97- 97- 97- 97-	procedure review, medical terview, the nurse executive ewborn assessment was to policy for 1 of 3 newborns ds were reviewed (N2). "Admission of Newborn", last dicated, "Initial assessmentVital signs including ions, pulse- Normal ranges: nute- 100- 160 without a sounds: 40- 60 without etractions, Axillary [Fahrenheit]. Initially on					
	every shift or every 4Documentation: 1. report to physician." 2. The medical recorbirth by C-section at 2	utes, 1 hour, 2 hours, then hours for 24 hours. Document all findings and d for patient N2 indicated 1430 on 11/09/11 with initial 'Upon delivery, infant not					

Indiana State Department of Health

STATE FORM 6899 06NX11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
744512747	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _		00111112		
		005093	B. WING		07/3	0/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
WITHAM I	WITHAM HEALTH SERVICES 2605 N LEBANON ST						
		LEBANON					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
	60 & 80. BMV (bag n Neopuff machine. HF greater than 100. Co pale. Tone decreased 3, 7. BMV was given then spontaneous res Patient with spontane decreased tone. Spo approx. 7 minutes of I nursery in order to ob check hemoglobin"	lor improved, but remained d, but improved. Apgars 1, for approx. 3 1/2 mins., spirations were adequate. ous movement, but overall ntaneous cry present. @ ife, patient was taken to the tain oxygen saturation and on indicated the infant was ry at approximately 10					
	documented at 1450 temperature of 97.8, I of 40, and blood presidocumented at 1520. temperature of 97.6, I respirations of 35 wer hour and 32 minutes documentation of who	neart rate of 40, respirations sure of 71/28 were Additional vital signs of					
	08/04/14, staff membor of OB reviewed the mand confirmed the asswas as follows: 1430-1450- oxygen saturatemperature of 97.8, I of 40, and blood prestemperature of 97.6, I	neart rate of 40, respirations sure of 71/28, and 1652- neart rate of 124, and aff member A2 confirmed					

Indiana State Department of Health

STATE FORM 6899 06NX11 If continuation sheet 3 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		005093	B. WING		07	//30/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
WITHAM I	HEALTH SERVICES		LEBANON ST				
	STIMMADA ST	ATEMENT OF DEFICIENCIES	ON, IN 46052	PROVIDER'S PLAN OF CO	OPPECTION	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S 936	Continued From page	3	S 936				
S 936	410 IAC 15-1.5-6 NU	RSING SERVICE	S 936				
	410 IAC 15-1.5-6 (b)(6)					
	(b) The nursing service following:	ce shall have the					
	(6) All nursing person demonstrate and doc fulfilling assigned res	ument competency in					
	record review, persor the facility failed to er Delivery) nurse (RN1	procedure review, medical nnel file review and interview, nsure 1 of 1 L&D (Labor &) had documentation of ncy in performing bedside					
	Findings included:						
	Nursing Personnel", I indicated, "Guidelines use of ultrasound by labor and delivery, an reasons for obtaining assess and obtain a f and determine fetal pDocument, and noti re-evaluation, or notif	"Ultrasound Performed by ast reviewed July 2014, is have been established for nursing personnel in the ad triage settingNursing a fetal ultrasound: To fetal heart rate. To assess resentation. Procedure: ify M.D. of results and/or for y Radiology Department for ling on patient if ordered."					
	admission to the OB of 11/09/11 for possible (induction of labor)/ Coposition of the baby.	d for patient N1 indicated an (Obstetrical) unit at 0624 on external version/IOL c-section because of breech Routine procedures were side ultrasound documented					

Indiana State Department of Health

STATE FORM 6899 06NX11 If continuation sheet 4 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		005093	B. WING		07	7/30/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE			
WITHAM I	HEALTH SERVICES		EBANON ST N, IN 46052				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
S 936	by RN1 indicated the down). Another beds confirmed the continu documented by RN1 3. The personnel file indicated license, certannual training were no issues or disciplina documentation of any performing bedside u 4. Per a telephone con 08/04/14, staff membultrasounds were only being signed off by the he/she indicated there	baby appeared vertex (head ide ultrasound that led vertex presentation was	S 936				

Indiana State Department of Health

STATE FORM 6899 06NX11 If continuation sheet 5 of 5